

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1916

## CERTIFICATE OF DEATH

Reg. Dist. No. 01919

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>HARFORD</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air, Md.</b>   |  | c. LENGTH OF STAY IN 1b<br><b>3 YRS</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>HARFORD COUNTY HOME</b>  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FOREST HILL</b>               |   |
| 94  |  | d. STREET ADDRESS<br><b>Bel Atr, Md.</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>JOHN</b>  |  | First<br><b>J.</b>   | Middle<br><b>BARRETT</b>  |
| 4. DATE OF DEATH<br><b>FEB. 26 1959</b>   |  | Month<br><b>FEB.</b>   | Day<br><b>26</b>  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>JAN. 23, 1982</b>  |  | 9. AGE (In years lost birthday)<br><b>77 yrs.</b>  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months<br><b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PRACTICAL MALE NURSE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |
| 13. FATHER'S NAME<br><b>RICHARD BARRETT</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY CONLEY</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>221-10-9419</b>  | 17. INFORMANT<br><b>Mrs. Helen B. Mattingly</b>   |
|   |  | <b>NONE</b>  | Address<br><b>P.O. 126, Leonardtown, Md.</b>  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.1 CORONARY THROMBOSIS</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br><b>Chr. Hypertensive Cardio-vascular disease</b>   |  | 10 yrs?  |   |
| DUE TO<br>(c)   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)                         |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>            | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State)   |
| 21. I certify that I attended the deceased from <b>Dec. 1955</b> , to <b>Feb. 26, 1959</b> , that I last saw the deceased alive on <b>Feb. 24, 1959</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above. |  |  |   |
| ACTUAL SIGNATURE<br><b>Willard P. Hudson</b>  |  | ADDRESS (Street, city or town, state)<br><b>Forest Hill, Md.</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>WILLARD P. HUDSON M.D.</b>  |  | DATE SIGNED<br><b>Feb. 26, 1959</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>2/28/59</b>  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Our Lady's</b>   |
| 22d. LOCATION (City, town, or county)<br><b>Hedley's Neck</b>   |  | (State)<br><b>Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. Clarke Mattingley Leonardtown, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 3 '59</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Frank</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1917

## CERTIFICATE OF DEATH

01920

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY **HARFORD**  
 CITY (If outside corporate limits, write RURAL  
 OR end give nearest town)  
 TOWN **BelAIR**

MARYLAND  
 LENGTH OF STAY  
 (in this place)  
**35 years**

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Feb 11/59** COUNTY **HARFORD**  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **BelAIR Md**  
 STREET  
 ADDRESS **Box 8 ST**  
 (If rural give location)

3. NAME OF  
DECEASED  
(Type or Print)

(First) **Walter** (Middle) **E** (Last) **BUNNINGTON**

4. DATE (Month) (Day) (Year)  
 OF DEATH **Feb 11 1959**

5. SEX **M**6. COLOR OR  
RACE **White**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) **MARRIED**10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired) **Retired**10b. KIND OF BUSINESS  
OR INDUSTRY **Policeman**11. BIRTHPLACE (State or foreign country) **Whitford Harford Md**

13. FATHER'S NAME

**Frederick BUNNINGTON**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) **Yes** (If Yes, give war or dates of service) **World War II**16. SOCIAL SECURITY NO. **215-22-8065**17. INFORMANT & ADDRESS **Florence TIGERT**

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**443X** IMMEDIATE CAUSE **CARDIAC ARREST**  
 ANTECEDENT CAUSE(S) DUE TO **HYPERTENSIVE CARDIOVASCULAR DISEASE**  
 DISEASES OR CONDITIONS, IF ANY, (B) DUE TO  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST. DUE TO  
 (C)

IMMEDIATE  
 10 YRSII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21e. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21c. WHERE DID INJURY OCCUR? (City or town)  
(County) (State)21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED  
M.  Not while   
at work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **MAR**, 19 **47**, to **FEB**, 19 **59**, that I last saw the deceasedalive on **9 Feb**, 19 **59**, and that death occurred at **4:15 AM**, from the causes and on the date stated above.SIGNATURE **HP Fidwell** M.D.DATE **FEB 13 '59** REGISTRAR'S SIGNATURE **Arthur & Fidwell**23. BURIAL, CREMATION,  
REMOVAL (SPECIFY) **Burial**DATE THEREOF **Feb 13/59**NAME OF CEMETERY OR CREMATORIAL  
ADDRESS **BelAIR Memorial Gardens**LOCATION (City, town, or county) **BelAIR Harford Md**

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE **Joseph T Foster**ADDRESS **BelAir Md**



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01921

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |  |
| Harford<br>MARYLAND   |  | a. STATE <input checked="" type="checkbox"/> Md<br>b. COUNTY <input checked="" type="checkbox"/> Harford   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | c. LENGTH OF STAY IN lb<br>65 years  |  |
| Bel Air   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | d. STREET ADDRESS<br>RD 2<br>RD 1  |  |
| RD 2  |  | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | First  | Middle   |
| Ray Van Lear  |  |  | Bowser   |
| 4. DATE<br>OF<br>DEATH  |  | Last   | JR   |
|   |  | Month  | February   |
|   |  | Day  | 28   |
|   |  | Year   | 1959   |
| 5. SEX  |  | 6. COLOR OR RACE   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH                     |
| M   |  | W  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Dec 4, 1938   |
| 9. AGE (in years<br>last birthday)  |  | 10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)  | 11. KIND OF BUSINESS OR INDUSTRY   |
| 20 yrs.   |  | Pipe Fitter Helper   | Ship yard  |
| 12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   |
| US  |  | Ray Van Lear Bowser SR   | Marie Mulligan   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT  |
| (If yes, give year or dates of service)   |  | 220-34-5906  | Ray Van Lear Bowser<br>Address<br>Box 219 RD 1 STOCKTON NY   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> Fracture skull<br>DUE TO<br>816 X   |  |  |  |
| Conditions, if any, which<br>gave rise to immediate cause<br>(b)  |  |  |  |
| (c)   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Auto accident auto - auto accident  |  |  |  |
| 20c. TIME OF INJURY<br>Hour<br>11:30<br>p. m.   |  | Month, Day, Year<br>2-28<br>1959   | 20d. INJURY OCCURRED<br>While<br>of work <input type="checkbox"/> Not while<br>of work <input checked="" type="checkbox"/> |
| 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)   |  | 20f. (City or town)<br>Bel Air   | (County) Maryland<br>(State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL<br>SIGNATURE<br>Gerald C Palmer  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | DATE SIGNED<br>3-1-59  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 22b. DATE THEREOF<br>Mar 4/1959  | 22c. NAME OF CEMETERY OR CREMATORIAL<br>Bel Air Memorial Gardens   |
| 22d. LOCATION (City, town, or county)<br>Bel Air Md   |  | (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Joseph J. Foster, Bel Air, Md.  |  | ADDRESS  | 24a. REC'D BY REGISTRAR<br>DATE MAR 4 '59  |
|   |  |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur & Evans   |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1918

## CERTIFICATE OF DEATH

Reg. Dist. No.

01922

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>HARFORD</i>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><i>MD</i>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>HARFORD, HARFORD</i>   |                                  | c. LENGTH OF STAY IN 1b<br><i>23 hrs</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>HARFORD MEMORIAL</i>   |                                  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Edgewood</i>  |   |
| 3. NAME OF DECEASED (Type or print)<br><i>HOWARD</i>  |                                  | First<br><i>Woodrow</i>  | Middle<br><i>Bull</i>                         |
| 4. SEX<br><i>Male</i>   | 5. COLOR OR RACE<br><i>White</i> | 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 7. DATE OF BIRTH<br><i>April 8, 1913</i>      |
| 8. AGE (In years<br>last birthday)<br><i>45</i>   |                                  | 9. IF UNDER 1 YEAR<br>Months<br><i>45</i>  | 10. IF UNDER 24 HRS.<br>Days<br>Hours<br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>CARPENTER</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Construction</i>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Md.</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |   |
| 13. FATHER'S NAME<br><i>Myron J. Bull Sr.</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Annie Elliott.</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>212-10-8887</i>  |   |
| 17. INFORMANT<br><i>Mr. Sewell Bull</i>   |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>331X</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c)                 |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  | 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   |
| 21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ A.M., from the causes and on the date stated above.<br>ACTUAL SIGNATURE<br><i>Peter P. Rodman, M.D.</i> |                                  | 22. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.<br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 22b. DATE THEREOF<br><i>Feb. 27, 1959</i>  |   |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br><i>BEL AIR MEMORIAL GARDENS</i>   |                                  | 22d. LOCATION (City, town, or county)<br>(State)<br><i>BEL AIR, HARFORD CO., MARYLAND</i>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Joseph W. Trotter</i>  |                                  | 24a. ADDRESS<br><i>W. Broadway &amp; Williams St.<br/>BEL AIR, MARYLAND</i>  |   |
| 24b. REC'D BY REGISTRAR<br><i>MAR 2 '59</i>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur E. K.</i>  |   |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1919

## CERTIFICATE OF DEATH

Reg. Dist. No. 01923

|   |                                  |  |  |  |                               |  |                               |
|---|----------------------------------|--|--|--|-------------------------------|--|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>HARFORD</b>  |                                  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>New Jersey</b> |                               | b. COUNTY<br><b>Gloucester</b>   |                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HARFORD DE GRACE</b>   |                                  | c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Clayton.</b>                    |                               | d. STREET ADDRESS<br><b>339 N. Pearl St.</b>   |                               |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>HARFORD MEMORIAL Hosp.</b>  |                                  |  |  | d. STREET ADDRESS<br><b>67x-3</b>  |                               | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |                               |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First<br><b>Jusanna</b>          | Middle   | Last<br><b>Campbell</b>                  | 4. DATE<br>OF<br>DEATH<br><b>Febrary 25 1959</b>   | Month                         | Day  | Year                          |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Dec. 18, 1870</b> | 9. AGE (In years<br>last birthday)<br><b>88 yrs.</b>   | 10. IF UNDER 1 YEAR<br>Months | 11. IF UNDER 24 HRS.<br>Days   | 12. IF UNDER 24 HRS.<br>Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Home Duties</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Phila Pa.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                               |
| 13. FATHER'S NAME<br><b>George W. Coward</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emily Smith</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>                                     |                               | 16. SOCIAL SECURITY NO.<br><b>—</b>  |                               |
| 17. INFORMANT<br><b>Mildred Hills - Abingdon MD</b>   |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>578x</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br><b>(b)</b><br>DUE TO<br><b>(c)</b> |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                               | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>(Bleeding from upper G.I. Tract<br/>(Not determined))</b><br><b>1 wk</b> |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |  |  |                               |  |                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |                               |  |                               |
| 20c. TIME OF INJURY<br>Hour a. m.<br>p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Nat white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town)<br>(County) (State)  |                               |
| 21. I certify that I attended the deceased from <b>Jan</b> , 1959, to <b>2-25</b> , 1959, that I last saw the deceased alive on <b>10-25-59</b> , and that death occurred at <b>10:45 PM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>Aberdeen, Md.</b> |                                  |  |  |  |                               |  |                               |
| ACTUAL<br>SIGNATURE<br><b>Peter P. Rodman, M.D.</b>   |                                  | DATE SIGNED<br><b>2-26-59</b>  |  |  |                               |  |                               |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Buried</b>   |                                  | 22b. DATE THEREOF<br><b>Feb 28/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Chickory Chapel</b>   |                               | 22d. LOCATION (City, town, or county)<br><b>Monroeville</b>  |                               |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Franklin R. Hamill, Jr., M.D.</b>  |                                  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 2 1959</b>  |                               | 24b. REGISTRAR'S SIGNATURE<br><b>Franklin R. Hamill, Jr., M.D.</b>   |                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, fold page 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS. Page 5 may be retained for reference. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, and in any event within 24 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01924

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  |  |
| Harford   |  | a. STATE Md  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | b. COUNTY Harford  |  |
| Bel Air   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |
| RD 2  |  | 2 years 6 Months Bel Air   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | d. STREET ADDRESS<br>12 Williams Street  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | First  | Middle   |
| Patricia (Te))  |  |  | Chadwick   |
| 4. DATE<br>OF<br>DEATH  |  | Month  | Day  |
| February  |  | Year   | 1959   |
| 5. SEX  |  | 6. COLOR OR RACE   | 7. MARRIED   |
| F   |  | W  | <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |
| 8. DATE OF BIRTH  |  | 9. AGE (In years<br>(In months)<br>10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)                                     |  |
| May 27-1941   |  | 10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)  |  |
| 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Washington DC   |  | 13. FATHER'S NAME  |  |
| George A Chadwick   |  | 14. MOTHER'S MAIDEN NAME   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  |
| MRS Dorothy R. RECKER   |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |
| 2 Williams St Bel Air MD  |  | 816X<br>Compound fracture skull  |  |
| DUE TO  |  | Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause last.  |  |
| (b)   |  | Fracture both femora   |  |
| DUE TO  |  | (c) Crushing injury chest  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour p.m. 2-28 1959  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>Bel Air Harford Md  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | ACTUAL<br>SIGNATURE<br>Gerald C Palmer   |  |
| EXAMINER'S<br>NAME (Type)   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 22b. DATE THEREOF<br>3/59  |  |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br>Bel Air Memorial Gardens  |  | 22d. LOCATION (City, town, or county)<br>(State)<br>Bel Air Md   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Joseph J. Foster, Bel Air, Md.  |  | 24a. REC'D BY REGISTRAR<br>MAR 4 '59   |  |
|   |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Thomas   |  |

MANUFACTURED BY THE STATE OF MARYLAND  
EXAMINER'S CERTIFICATE OF REGISTRATION

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1920

## CERTIFICATE OF DEATH

Reg. Dist. No. 11825

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE |  |
| Harford   |   | MARYLAND  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   | c. LENGTH OF STAY IN 1b<br>31   |  |
| Harmer-de-Grace   |   | 47 days.  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION   |   | e. STREET ADDRESS   |  |
| Harford Memorial Hospital   |   | Paradise Rd.  |  |
| f. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First   | Middle  | Last   |
| Female  | Elizabeth   | Hollis  | Coale  |
| 4. DATE<br>OF<br>DEATH  | Month   | Day   | Year   |
|   | 2   | 4   | 1959.  |
| 5. SEX  | 6. COLOR OR RACE  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                        | B. DATE OF BIRTH   |
| Female  | White   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                     | July 8th. 1888   |
| 8. AGE (In years<br>last birthday)  | 9. IF UNDER 1 YEAR<br>yrs.  | 10. IF UNDER 24 HRS.  |  |
| 70  | Months  | Days  |  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)   | 12. CITIZEN OF WHAT COUNTRY?                                   |
| House-wife  | HOME  | Pa  | U.S.A.   |
| 13. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME  |   |  |
| William Hannah Smith.   | Mary Hendon.  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT   | Address  |
| No  | —   | Mrs. Clyde Foote, Aberdeen, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   | INTERVAL BETWEEN<br>ONSET AND DEATH   |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   | Carcinoma of the abdomen  |   |  |
| 199.2   | 3 mo.   |   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last. (b)   | DUE TO  |   |  |
|   | DUE TO  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |
| Arteriosclerotic heart disease  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)    |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            | 20f. (City or town) (County) (State)                           |
|   |   | 1953  | 2 - 4 - 1959   |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased<br>alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above. | ADDRESS (Street, city or town, state) DATE SIGNED   |   |  |
| ACTUAL<br>SIGNATURE   | 8 Law Street  |   |  |
| PHYSICIAN'S<br>NAME (Type)  | Peter P. Rodman   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   | 22b. DATE THEREOF<br>2/7/59   | 22c. NAME OF CEMETERY OR CREMATORIAL<br>Trinity Episcopal Com.                                    | 22d. LOCATION (City, town, or county)<br>Churchville, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>John G. Jarrung   | ADDRESS<br>Aberdeen, Md.  | 24a. REC'D BY REGISTRAR<br>DATE FEB 10 59   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Krause                 |





STATE OF CALIFORNIA  
DEPARTMENT OF JUSTICE  
CRIMINAL EXAMINERS' LABORATORY

SEARCHED

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THIS INFORMATION

IS FOR OFFICE USE ONLY

17-14-3741 FEB 12 1968 BY [illegible] HANSON, GENE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

81927

## 1921 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 8 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED   |   |
| COUNTY  | Harford  | MARYLAND  | STATE Maryland  |
| CITY (If outside corporate limits, write RURAL or and give nearest town)  |  | LENGTH OF STAY (in this place)  | CITY (If outside corporate limits, write RURAL and give nearest town) |
| TOWN  | Bel Air  | 30  | OR TOWN   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   | Fulford AVE.   | STREET ADDRESS  | 1 Fulford AVE. (If rural give location)                               |
| 3. NAME OF DECEASED (First) Nicholas J. DEMAS (Middle) (Last)   |  | 4. DATE (Month) (Day) (Year) OF DEATH Feb. 17, 1959   |   |
| 5. SEX M  | 6. COLOR OR RACE W   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married  | 8. DATE OF BIRTH JUNE 5, 1892   |
| 9. AGE last birthday 66 yrs.  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Proprietor | 11. KIND OF BUSINESS OR INDUSTRY Restaurant   | 12. BIRTHPLACE (State or foreign country) Trikkala, GREECE            |
| 13. FATHER'S NAME JAMES DEMAS   | 14. MOTHER'S M AIDEN NAME HELEN DEMAS  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO  | 16. SOCIAL SECURITY NO. 214-34-4565  | 17. INFORMANT & ADDRESS Mrs. Mary Charas DEMAS 102 Fulford AVE. Bel Air, Md.                              |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |   |   |
| 420.1 IMMEDIATE CAUSE (A) Myocardial infarction   |  | INTERVAL BETWEEN ONSET AND DEATH 1/2 hour   |   |
| ANTECEDENT CAUSE(S) DUE TO (B) Coronary thrombosis  |  | several hours   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) ARTERIOSCLEROTIC and hypertension cardiovascular disease  |  | 10 years  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Intermittent congestive heart failure  |  | 5 years   |   |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                    |   |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |  |   |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |  | 21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   |
|   |  | 21f. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from Aug. 13, 1954, to FEB. 17, 1959, that I last saw the deceased alive on FEB. 17, 1959, and that death occurred at 9:30 A.M. from the causes and on the date stated above. |  |   |   |
| SIGNATURE Paul J. Stoenys Jr.   |  |   |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | DATE THEREOF 2/20/1959  |   |
|   |  | NAME OF CEMETERY OR CREMATORIUM Bel Air Memorial GARDENS  |   |
| 24. REC'D BY REGISTRAR  |  | REGISTRAR'S SIGNATURE C. Stoenys Jr.  |   |
| DATE FEB 20 59  |  | 25. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Trotter  |   |
|   |  | ADDRESS 115 FULFORD AVE. BEL AIR, MD. 2/18/59   |   |
|   |  | LOCATION (City, town, or county) BEL Air, Harford Co., Maryland   |   |
|   |  | (State)   |   |
|   |  | ADDRESS W. Broadway + Williams St. BEL Air, Maryland  |   |

OF BROWNSVILLE-NTIAH TO THEIR TRADED STATE CHAUFFEUR

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81  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1934 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01928

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  | Harford MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  | Conowingo   |   | a. STATE Penna b. COUNTY Phila  |
| c. LENGTH OF STAY IN 1b   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   |   | d. STREET ADDRESS   |
| Hopkins Cone, Susquehanna River   |   |   | 75 x-3  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First   | Middle  | 4. DATE<br>OF<br>DEATH  |
| H. W.   |   | Hanser  | February 27 1959  |
| 5. SEX  | 6. COLOR OR FACE  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH   | 9. AGE (in years<br>last birthday)<br>69 yrs.   |
| M   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | Nov. 19 1889  | 10. UNDER 1 YEAR<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)   |
| Retired Engineer  |   | Phila Electr. & Steel   | 12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME   |   | 14. MOTHER'S MAIDEN NAME  |   |
| James Hansen  |   | Marie Christenson   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, name unknown)  |   | 16. SOCIAL SECURITY NO. 17. INFORMANT   |   |
| (If yes, give war or dates of service)  |   | Am. J. Hansen Kemby Rose<br>Address: Upper Party Rd., Phila, Pa.  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |   |   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 863X<br>Decerebration   |   |   |   |
| DUE TO<br>(b) Third degree burns entire body  |   |   |   |
| DUE TO<br>(c)   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Helicopter hit power wire & crashed |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. 2-27-59<br>p. m.  |   | 20d. INJURY OCCURRED<br>White Not white<br>of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>             |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>Susquehanna River   |   | 20f. (City or town) Conowingo Harford (County) Md. (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)  | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |
| 22a. BURIAL, Cremation, or Removal, DATE THEREOF<br>REMOVAL (Specify)   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Feb. 28, 1959 Nashville Tenn.   |   |
| 22d. LOCATION (City, town or county)<br>Out of Phila, Penna.  |   | (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>ADDRESS<br>768 Bailey Harlington MD   |   | 24a. REC'D BY REGISTRAR<br>DATE MAR 5 '59   |   |
|   |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Krause  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1935

## CERTIFICATE OF DEATH

Reg. Dist. No. 01929

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jarrettsville</b> |  | c. LENGTH OF STAY IN 1b<br><b>1 mon.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION                             |  | X Street<br>d. STREET ADDRESS  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ANNIE</b>   |  | First<br><b>MARY</b>   | Middle<br><b>Haslett.</b>   |
| 4. DATE OF DEATH<br><b>Feb. 17 1959</b>  |  | Month<br><b>Feb.</b>   | Day<br><b>17</b>  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>May 29, 1884</b>  |  | 9. AGE (In years last birthday)<br><b>74 yrs.</b>  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Shane, Balto. Co. Md.</b>                                |  | 12. IF UNDER 24 HRS.<br>Days<br><b>0</b>   | 13. IF UNDER 24 HRS.<br>Hours<br><b>0</b>   |
| 14. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Mc Clairy</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>0-0-0000</b>   |  | 17. INFORMANT<br><b>Lewie W. Haslett</b>   |   |
| 18. ADDRESS<br><b>Street, Maryland</b>   |  | 19. INTERVAL BETWEEN ONSET AND DEATH<br><b>Years -</b>   |   |
| 20. MEDICAL CERTIFICATION  |  | 21. I certify that I attended the deceased from <b>Sept. 1958</b> to <b>17 Feb. 1959</b> , that I last saw the deceased alive on <b>17 Feb. 1959</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above. |   |
| 22. ACTUAL SIGNATURE<br><i>Thos. A. Morley Jr.</i>   |  | ADDRESS (Street, city or town, state)<br><b>Jarrettsville, Md.</b>   |   |
| 23. PHYSICIAN'S NAME (Type)<br><b>William Watters</b>  |  | DATE SIGNED<br><b>1959</b>   |   |
| 24. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 25. DATE THEREOF<br><b>2/19/1959</b>   |   |
| 26. NAME OF CEMETERY OR CREMATORIAL<br><b>William Watters</b>  |  | 27. LOCATION (City, town, or county)<br><b>Cooptown</b>  |   |
| 28. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles E. Kurtz</b>  |  | 29. ADDRESS<br><b>Jarrettsville, Md.</b>   |   |
| 30. REC'D BY REGISTRAR<br><b>FEB 24 '59</b>  |  | 31. REGISTRAR'S SIGNATURE<br><b>Orion S. Knott</b>   |   |



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1922 CERTIFICATE OF DEATH

01930

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY **Harford**  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN **Havre de Grace**

MARYLAND

LENGTH OF STAY  
 (In this place)

20 Min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland** COUNTY **Harford**  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **Forest Hill** Rural  
 STREET ADDRESS  
 (If rural give location)

3. NAME OF  
 DECEASED  
 (Type or Print)**DORA****ALBERTA****HORN**4. DATE (Month) (Day) (Year)  
**February 2, 1959**

## 5. SEX

6. COLOR OR  
 RACE7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify)

## 8. DATE OF BIRTH

9. AGE last birthday  
 yrs.10. IF UNDER 1 YEAR  
 Months Days Hours Min.

Female

White

Married

Feb. 9, 1898

60

10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired)10b. KIND OF BUSINESS  
 OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Housewife

Home

Pa.

12. CITIZEN OF WHAT  
 COUNTRY?**U. S. A.**

## 13. FATHER'S NAME

**Samuel Robb**

## 14. MOTHER'S MAIDEN NAME

**Emma Coler**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

**Mrs. Harvey Keys Forest Hill Md.**INTERVAL BETWEEN  
 ONSET AND DEATH

2 or 3 hours

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A) **Pulmonary Edema, acute**

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST, DUE TO

(C) **Arteriosclerotic cardiovascular disease**

1 year

10 years

2 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.**Diabetes mellitus**

## 19e. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While at work  Not while at work 

## 22. I hereby certify that I attended the deceased from

Jan. 15, 1957, to Feb. 1, 1959, that I last saw the deceased alive on Feb. 1, 1959, and that death occurred at 6:50 AM, from the causes and on the date stated above.

## SIGNATURE

*Paul S. Stonesifer, Jr.*

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town, or county)

(State)

**Burial**

2/4/1959

**Bel Air Memorial Garden****Bel Air**

2/2/59

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

DATE FEB 4 '59

*Arthur S. Hayes**Charles C. Hunt Garrettsville Md.*



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1936

## CERTIFICATE OF DEATH

Reg. Dist. No. 01931

|  |  |  |   |      |
|--|--|--|---|------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Hanover</i>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><i>Md.</i>  |   |      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Aberdeen</i>  |  | c. LENGTH OF STAY IN 1b<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Aberdeen (Rural)</i>                         |   |      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><i>R.D. #1, Box 364</i>   |  | d. STREET ADDRESS<br><i>R.D. #1, Box 364</i>   |   |      |
| e. IS RESIDENCE<br>ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |      |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><i>FRANKLIN O. Johnson</i>  |  | First  | Middle  |      |
| 4. DATE<br>OF<br>DEATH<br><i>February 18 1959</i>  |  | Lost   | Month   |      |
|  |  | 4. DATE<br>OF<br>DEATH<br><i>February 18 1959</i>  | Day   | Year |
| 5. SEX<br><i>M</i>   |  | 6. COLOR OR RACE<br><i>W</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |      |
| 8. DATE OF BIRTH<br><i>Sept 24, 1916</i>   |  | 9. AGE (In years<br>lost birthday<br>yrs.)<br><i>42</i>  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months<br>Days<br>Hours<br>Min.   |      |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><i>Farmer</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Farm</i>   | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |      |
| 13. FATHER'S NAME<br><i>Oscar M. Johnson</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Mary Alice Palmer</i>   |   |      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.<br><i>219-07-4878</i>  | 17. INFORMANT<br><i>Ruth Greenland, Aberdeen, Maryland</i>  |      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>162.1</i>   |  | R  |   |      |
| DUE TO<br><i>Lung.</i>   |  | INTERVAL BETWEEN<br>ONSET AND DEATH  |   |      |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the <u>under-</u><br>lying cause lost.<br>(b)<br>DUE TO<br>(c)   |  |  |   |      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.   |  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State)  |      |
| 21. I certify that I attended the deceased from <i>6-15</i> , 19 <i>58</i> , to <i>2-18</i> , 19 <i>59</i> , that I last saw the deceased<br>alive on <i>2-18</i> , 19 <i>59</i> , and that death occurred at <i>9 P</i> M, from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE <i>Gerald C Palmer</i> M.D. ADDRESS (Street, city, or town, state)<br>PHYSICIAN'S<br>NAME (Type) <i>Gerald C Palmer - M.D.</i> DATE SIGNED <i>2-18-59</i> |  |  |   |      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 22b. DATE THEREOF<br><i>2/21/59</i>  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Spesutia Cemetery</i>  |      |
| 22d. LOCATION (City, town, or county)<br>(State)   |  | 22d. LOCATION (City, town, or county)<br>(State)   |   |      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Tarring</i>   |  | ADDRESS <i>Tarring Funeral Home</i>  | REGISTRAR <i>Perryman</i>   |      |
|  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Keay</i>  |   |      |
|  |  | DATE <i>FEB 24 '59</i>   |   |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1932

1937

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |   |  |  |   |                                      |      |
|--|----------------------------------|---|---|--|--|---|--------------------------------------|------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Harford</b> |  |   |                                      |      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Edgewood</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>16 yrs.,</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Edgewood</b>  |  | d. STREET ADDRESS   |                                      |      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |                                      |      |
| 3. NAME OF DECEASED (Type or print)<br><b>Mary</b>   |                                  | First   | Middle <b>Regina</b>  | Last <b>Johnson</b>  | 4. DATE OF DEATH<br><b>Feb. 1, 1959</b>                                | Month   | Day                                  | Year |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 13, 1900</b>  | 9. AGE (in years last birthday)<br><b>58</b>   | 10. IF UNDER 1 YEAR<br>yrs.<br><b>58</b>                               | 11. IF UNDER 24 HRS.<br>Months<br>Days<br>Hours<br>Min.                             |                                      |      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laboratory Tech.,</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.,</b>                               |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.,</b>                                      |                                      |      |
| 13. FATHER'S NAME<br><b>Harry G. Smith</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |   |                                      |      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>no   |                                  |   | 16. SOCIAL SECURITY NO. <b>218-22-0997</b>  |  |  | 17. INFORMANT<br><b>Boyd N. Johnson, Edgewood, Maryland</b>                         |                                      |      |
| Address  |                                  |   |   |  |  |   |                                      |      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>171X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>Metastasis thru out Abdomen</b> (b) DUE TO<br><b>Hemorrhage, leading to Cacnoma</b> (c) |                                  |   |   |  |  |   |                                      |      |
| INTERVAL BETWEEN ONSET AND DEATH   |                                  |   |   |  |  |   |                                      |      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |   |  |  |   |                                      |      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |   |                                      |      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State) |      |
| 21. I certify that I attended the deceased from <b>1/1/28</b> , 19 <b>58</b> , to <b>2/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/1/59</b> , and that death occurred at <b>10:35</b> M, from the causes and on the date stated above.   |                                  |   | ADDRESS (Street, city or town, state)   |  |  |   |                                      |      |
| ACTUAL SIGNATURE<br><b>E. Louis Kahan</b>  |                                  |   | DATE SIGNED<br><b>Feb 9 66 Edgewood MD</b>  |  |  |   |                                      |      |
| PHYSICIAN'S NAME (Type)<br><b>E. Louis Kahan</b>   |                                  |   | REG. Edgewood Maryland  |  |  |   |                                      |      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Feb. 4, 1959</b>  |   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Bel Air Memorial Gardens</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Bel Air, Harford, Maryland.</b> |                                      |      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard L. McNamee</b>   |                                  |   | ADDRESS<br><b>Abingdon, Maryland.</b>   |  |  | 24a. REC'D BY REGISTRAR<br><b>DATE FEB 5 '59</b>                                    |                                      |      |
|  |                                  |   |   |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Orville S. Krause</b>                              |                                      |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

## CERTIFICATE OF DEATH

STATE OF HAWAII - DEPARTMENT OF HEALTH

Date:

Place:

Cause:

Reported:

Name:

Date:

Name:

Age:

Name:

Age:

Sex:

Place:

Sex:

A.B.U.

Baltimore, Maryland

U.S. Govt.

Department of Health

Name:

Marilyn Smith

Name of Hospital:

Body of Person:

158-55-031

to

Name:

Name:

Cause of Death:

Name of Hospital: Date of Death: Name of Doctor:

Cause of Death:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1938 CERTIFICATE OF DEATH

01933

Reg. Dist. No.

|   |                                  |  |  |  |  |  |   |  |
|---|----------------------------------|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b>  |                                  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Harford</b>  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>17 Min</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>                  |  | d. STREET ADDRESS<br><b>16 Chesapeake Court</b>  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>US ARMY HOSPITAL ABERDEEN<br/>PROVING GROUND, MARYLAND</b>  |                                  |  |  | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |  |   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>First<br/>FREELAND</b>  |                                  | Middle<br><b></b>  |  | 4. DATE<br>OF<br>DEATH<br><b>14 Feb 59</b>   |  | Month<br><b>February</b>   | Day<br><b>14</b>                          | Year<br><b>19 59</b>                     |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>14 Feb 59</b>   |  | 9. AGE (In years<br>lost birthday)<br>yrs.<br><b>17</b>  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b> | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>N/A</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |
| 13. FATHER'S NAME<br><b>Carroll Freeland Jones</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Gloria Hannon</b>   |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Father</b>   |  | Address<br><b>16 Chesapeake Ct<br/>Aberdeen Md</b>   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity (Preivable Infant)</b><br>DUE TO<br>776X<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost. (b)<br>DUE TO<br>(c) |                                  |  |  |  |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>17 min</b>   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)   |                                  |  |  |  |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour<br>o. m.<br>p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br>(County)<br>(State)   |   |  |
| 21. I certify that I attended the deceased from <b>1:03PM 14 Feb 59</b> to <b>1:20PM 14 Feb 59</b> , that I last saw the deceased alive on <b>1:20PM 14 Feb 19 59</b> , and that death occurred at <b>1:20PM</b> , from the causes and on the date stated above.  |                                  |  |  |  |  | ADDRESS (Street, city or town, state)  |   |  |
| ACTUAL<br>SIGNATURE<br><i>Charles H P Westfall</i>  |                                  |  |  |  |  | DATE SIGNED<br><b>14 Feb 59</b>  |   |  |
| PHYSICIAN'S<br>NAME (Type)<br><b>CHARLES H P WESTFALL MAJOR MC</b>  |                                  | US ARMY HOSPITAL Aberdeen PG Md  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION,<br>MOVES (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>2-18-59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Post Cemetery</b>   |  | 22d. LOCATION (City, town, or county)<br>(State)<br><b>A. P. G. Aberdeen, Md.</b>                    |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Otis J. Bullock - Haven de Grace, Md.</i>  |                                  | ADDRESS<br><b>2050261XVO</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 20 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Krause</i>  |   |  |

100 PROBLEMS - READING & WRITING STATE TESTS  
ATTACHED STAPLED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01934

1939

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                           |   |  |
|---|---------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE                               |  |
| Harford MARYLAND  |                           | Maryland b. COUNTY Harford  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural, Aberdeen   |                           | c. LENGTH OF STAY IN 1b<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural, Aberdeen, |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>ROUTE #1, Box 72  |                           | d. STREET ADDRESS<br>Route #1, Box 72   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           |   |  |
| 3. NAME OF DECEASED (Type or print)<br>CHARLES ALONZO KEITHLEY  |                           | First   | Middle                                     |
|   |                           | Last  | 4. DATE OF DEATH<br>February 1 1959        |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | B. DATE OF BIRTH<br>20 Sept. 1877          |
|   |                           | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 9. AGE (In years last birthday) yrs.<br>81 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Painter  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Painting   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>James Keithley   |                           | 14. MOTHER'S MAIDEN NAME<br>Cathrine Cullum   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |                           | 16. SOCIAL SECURITY NO. 218-14-2358   |  |
| No  |                           | 17. INFORMANT<br>Mrs. Chas. Alonzo Keithley, Aberdeen, Md.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                           | Address R.D. 1, B.72  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>420.0  |                           | INTERVAL BETWEEN<br>ONSET AND DEATH<br>2 wk   |  |
| DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.   |                           | Congestive heart failure<br>Anterior sclerotic heart disease  |  |
| (b)<br>DUE TO<br>(c)  |                           | 6 yr.   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                    |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                       |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from 1959, 19, to 2-1-, 1959, that I last saw the deceased alive on 1959, and that death occurred at 7:30PM, from the causes and on the date stated above. |                           | ADDRESS (Street, city or town, state) DATE SIGNED<br>8 Law Street   |  |
| ACTUAL SIGNATURE<br><i>Peter P. Rodman</i>  |                           | M.D.  |  |
| PHYSICIAN'S NAME (Type)<br>Peter P. Rodman  |                           | Aberdeen, Md.   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>2/11/1959  |  |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br>St. Paul Luthern  |                           | 22d. LOCATION (City, town, or county) (State)<br>R.D. Aberdeen, Maryland  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>John G. Tarrung</i>  |                           | ADDRESS Tarring Funeral Home<br>Aberdeen, Md.   |  |
|   |                           | 24a. REC'D BY REGISTRAR<br>DATE FEB 5 '59   |  |
|   |                           | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>  |  |



1  
FOR STATE  
HEALTH DEPT.  
IN  
VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
ITEMS 13 & 17—FILE G240-213759-RB  
1940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 2 FILE G239 3-9-59 et

01935

Reg. Dist. No.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |   |
| Harford<br>MARYLAND   |  | a. STATE   | b. COUNTY   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL<br>and give nearest town)<br>Conowingo  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Villanova  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Hopkinsone, Susquehanna River   |  | d. STREET ADDRESS<br>609 Spruce Lane   |   |
| e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | e. DATE OF DEATH<br>February 27 1939   |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | First  | Middle  |
| 4. DATE<br>OF<br>DEATH  |  | Last   | Month   |
| 5. SEX  |  | 6. COLOR OR RACE   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH |
| M   |  | W  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                          |
| 9. AGE (In years<br>last birthday)<br>72 yrs.   |  | 10. UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Engineer (Electrical Co)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br>Pa   |  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br>Walter Klapper   |  | 14. MOTHER'S MAIDEN NAME<br>Dora Radther   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No, or unknown)   |  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br>Mary Har 11  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>863X<br>DUE TO<br>Fracture both femora                               |   |
| Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause last.   |  | INTERVAL BETWEEN<br>ONSET AND DEATH  |   |
| DUE TO<br>(b)   |  | Fracture both femora   |   |
| DUE TO<br>(c)   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Helicopter hit power line  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour<br>6 p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>Susquehanna River, Conowingo, Harford, Md.  |  | 20f. (City or town)<br>(County)<br>(State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL<br>SIGNATURE<br>GERALD E. PALMER   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br>Baltimore, Md. 2-27-59 |   |
| EXAMINER'S<br>NAME (Type)   |  | 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Feb. 28, 1959  |   |
| 22c. NAME OF CEMETERY OR CREMATORIUM<br>West Laurel Hill  |  | 22d. LOCATION (City, town, or County)<br>Philadelphia, Pa. (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>C. Wallace Steward Jr.  |  | ADDRESS<br>Ardmore, Pa.  |   |
| 24a. REC'D BY REGISTRAR<br>DATE MAR 5 '59   |  | 24b. REGISTRAR'S SIGNATURE<br>Cecilia S. Kraus   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01936

Reg. Dist. No.

|   |  |   |                                      |
|---|--|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Harford</i>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><i>Md</i>  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Street</i>   |  | c. LENGTH OF STAY IN 1b<br><i>1 month</i>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION   |  | e. STREET ADDRESS<br><i>1000 street</i>   |                                      |
| f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |                                      |
| 3. NAME OF DECEASED (Type or print)<br><i>Ralph</i>   |  | First   | Middle                               |
| 4. DATE OF DEATH<br><i>Feb. 17 1959</i>   |  | 1. Lost   | Month                                |
| 5. SEX<br><i>Male</i>   |  | 2. DATE OF BIRTH<br><i>July 4 1896</i>  | Day                                  |
| 6. COLOR OR RACE<br><i>White</i>  |  | 3. AGE (In years<br>last birthday)<br><i>62</i>   | Year                                 |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 4. IF UNDER 1 YEAR<br>Months <i>0</i>   | 5. IF UNDER 24 HRS.<br>Days <i>0</i> |
| 8. AGE (In years<br>last birthday)<br><i>62</i>   |  | 6. HOURS <i>0</i>   | 7. MIN. <i>0</i>                     |
| 9. DATE OF BIRTH<br><i>July 4 1896</i>  |  | 8. IF UNDER 1 YEAR<br>Months <i>0</i>   | 9. IF UNDER 24 HRS.<br>Days <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired Wool Maker</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Wool</i>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><i>Harford Co Md</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                                      |
| 13. FATHER'S NAME<br><i>Wilson Knight</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Bessie Lowe</i>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>No</i>  |  | 16. SOCIAL SECURITY NO.<br><i>Robert Knight 249-52-0000</i>   |                                      |
| 17. INFORMANT<br><i>Robert Knight</i>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>434.2</i><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause first.<br><i>Acute Heart Attack</i> |                                      |
|   |  | DUE TO<br><i>Cardiac Arrest</i>   |                                      |
|   |  | DUE TO<br><i>1 y.</i>   |                                      |
| 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.<br><i>19</i>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County) (State)   |                                      |
| 21. I certify that I attended the deceased from <i>Jan 15 1959</i> to <i>Feb 17 1959</i> that I last saw the deceased alive on <i>Feb 15 1959</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. |  | ADDRESS (Street, city or town, state)<br><i>Washington, D.C.</i>  |                                      |
| ACTUAL<br>SIGNATURE<br><i>P. S. Bradgate</i>  |  | DATE SIGNED<br><i>Feb 18 1959</i>   |                                      |
| PHYSICIAN'S<br>NAME (Type)<br><i>P. S. Bradgate</i>   |  |   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (specify)<br><i>Feb 19 1959</i>   |  | 22b. DATE THEREOF<br><i>Feb 19 1959</i>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Lorraine Cem</i>   |  | 22d. LOCATION (City, town, or county)<br>(State)<br><i>Baltimore, Md.</i>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>H. D. Bailey</i>   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><i>Feb 24 '59</i>  |                                      |
| ADDRESS<br><i>1000 street</i>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>  |                                      |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1923 CERTIFICATE OF DEATH

Reg. Dist. No. 11957

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air</b>  |  | c. LENGTH OF STAY IN lb<br><b>35 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Harford Conv. Home</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air</b>  |  |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>Ella</b>  |  | d. STREET ADDRESS<br><b>Rt. # 2</b>   |  |  |  |
| 4. DATE<br>OF<br>DEATH<br><b>February 8 1959</b>  | Month<br>Day<br>Year                                   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>                       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                           | 8. DATE OF BIRTH<br><b>August 7, 1880</b>                          |  |  |
| 9. AGE (In years<br>last birthday)<br><b>78</b>   | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>              | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>  | 12. IF UNDER 24 HRS.<br>Hours<br><b>0</b>                          |  |  |
| 13. 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Housewife</b>  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>House work</b> | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                      |  |  |
| 14. FATHER'S NAME<br><b>Johnson Duncan</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ruth Peters</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Mrs. Lillian Trusler, R. # 3, Bel Air, Md.</b> |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.1</b>  |  | INTERVAL/BETWEEN<br>ONSET AND DEATH<br><b>2 hrs.</b>  |  |  |  |
| DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br><b>Chr Cardio-vascular disease</b>   |  | ?   |  |  |  |
| DUE TO<br><b>With hypertension</b>  |  | 12 yrs.   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Hemiplegia (left side) due to cerebral vascular disease</b>   |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY Month, Day, Year<br/>Hour o. n. 19<br/>p. m. While at work</b> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |  |
| 21. I certify that I attended the deceased from <b>May 1950</b> , 19, to <b>Feb. 8</b> , 1959, that I last saw the deceased<br>alive on <b>Feb. 7</b> , 1959, and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE <b>Willard P. Hudson, M.D.</b> |  | ADDRESS (Street, city or town, state)<br><b>Forest Hill, Md.</b>  |  | DATE SIGNED<br><b>2/9/59</b>   |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>2/11/59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Bel Air Memorial Gardens</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph T. Foster</b>   |  | ADDRESS<br><b>Bel Air, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 '59</b>  |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krause</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |    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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 8010 | 8011 | 8012 | 8013 | 8014 | 8015 | 8016 | 8017 | 8018 | 8019 | 8020 | 8021 | 8022 | 8023 | 8024 | 8025 | 8026 | 8027 | 8028 | 8029 | 8030 | 8031 | 8032 | 8033 | 8034 | 8035 | 8036 | 8037 | 8038 | 8039 | 8040 | 8041 | 8042 | 8043 | 8044 | 8045 | 8046 | 8047 | 8048 | 8049 | 8050 | 8051 | 8052 | 8053 | 8054 | 8055 | 8056 | 8057 | 8058 | 8059 | 8060 | 8061 | 8062 | 8063 | 8064 | 8065 | 8066 | 8067 | 8068 | 8069 | 8070 | 8071 | 8072 | 8073 | 8074 | 8075 | 8076 | 8077 | 8078 | 8079 | 8080 | 8081 | 8082 | 8083 | 8084 | 8085 | 8086 | 8087 | 8088 | 8089 | 8090 | 8091 | 8092 | 8093 | 8094 | 8095 | 8096 | 8097 | 8098 | 8099 | 80100 | 80101 | 80102 | 80103 | 80104 | 80105 | 80106 | 80107 | 80108 | 80109 | 80110 | 80111 | 80112 | 80113 | 80114 | 80115 | 80116 | 80117 | 80118 | 80119 | 80120 | 80121 | 80122 | 80123 | 80124 | 80125 | 80126 | 80127 | 80128 | 80129 | 80130 | 80131 | 80132 | 80133 | 80134 | 80135 | 80136 | 80137 | 80138 | 80139 | 80140 | 80141 | 80142 | 80143 | 80144 | 80145 | 80146 | 80147 | 80148 | 80149 | 80150 | 80151 | 80152 | 80153 | 80154 | 80155 | 80156 | 80157 | 80158 | 80159 | 80160 | 80161 | 80162 | 80163 | 80164 | 80165 | 80166 | 80167 | 80168 | 80169 | 80170 | 80171 | 80172 | 80173 | 80174 | 80175 | 80176 | 80177 | 80178 | 80179 | 80180 | 80181 | 80182 | 80183 | 80184 | 80185 | 80186 | 80187 | 80188 | 80189 | 80190 | 80191 | 80192 | 80193 | 80194 | 80195 | 80196 | 80197 | 80198 | 80199 | 80200 | 80201 | 80202 | 80203 | 80204 | 80205 | 80206 | 80207 | 80208 | 80209 | 80210 | 80211 | 80212 | 80213 | 80214 | 80215 | 80216 | 80217 | 80218 | 80219 | 80220 | 80221 | 80222 | 80223 | 80224 | 80225 | 80226 | 80227 | 80228 | 80229 | 80230 | 80231 | 80232 | 80233 | 80234 | 80235 | 80236 | 80237 | 80238 | 80239 | 80240 | 80241 | 80242 | 80243 | 80244 | 80245 | 80246 | 80247 | 80248 | 80249 | 80250 | 80251 | 80252 | 80253 | 80254 | 80255 | 80256 | 80257 | 80258 | 80259 | 80260 | 80261 | 80262 | 80263 | 80264 | 80265 | 80266 | 80267 | 80268 | 80269 | 80270 | 80271 | 80272 | 80273 | 80274 | 80275 | 80276 | 80277 | 80278 | 80279 | 80280 | 80281 | 80282 | 80283 | 80284 | 80285 | 80286 | 80287 | 80288 | 80289 | 80290 | 80291 | 80292 | 80293 | 80294 | 80295 | 80296 | 80297 | 80298 | 80299 | 80300 | 80301 | 80302 | 80303 | 80304 | 80305 | 80306 | 80307 | 80308 | 80309 | 80310 | 80311 | 80312 | 80313 | 80314 | 80315 | 80316 | 80317 | 80318 | 80319 | 80320 | 80321 | 80322 | 80323 | 80324 | 80325 | 80326 | 80327 | 80328 | 80329 | 80330 | 80331 | 80332 | 80333 | 80334 | 80335 | 80336 | 80337 | 80338 | 80339 | 80340 | 80341 | 80342 | 80343 | 80344 | 80345 | 80346 | 80347 | 80348 | 80349 | 80350 | 80351 | 80352 | 80353 | 80354 | 80355 | 80356 | 80357 | 80358 | 80359 | 80360 | 80361 | 80362 | 80363 | 80364 | 80365 | 80366 | 80367 | 80368 | 80369 | 80370 | 80371 | 80372 | 80373 | 80374 | 80375 | 80376 | 80377 | 80378 | 80379 | 80380 | 80381 | 80382 | 80383 | 80384 | 80385 | 80386 | 80387 | 80388 | 80389 | 80390 | 80391 | 80392 | 80393 | 80394 | 80395 | 80396 | 80397 | 80398 | 80399 | 80400 | 80401 | 80402 | 80403 | 80404 | 80405 | 80406 | 80407 | 80408 | 80409 | 80410 | 80411 | 80412 | 80413 | 80414 | 80415 | 80416 | 80417 | 80418 | 80419 | 80420 | 80421 | 80422 | 80423 | 80424 | 80425 | 80426 | 80427 | 80428 | 80429 | 80430 | 80431 | 80432 | 80433 | 80434 | 80435 | 80436 | 80437 | 80438 | 80439 | 80440 | 80441 | 80442 | 80443 | 80444 | 80445 | 80446 | 80447 | 80448 | 80449 | 80450 | 80451 | 80452 | 80453 | 80454 | 80455 | 80456 | 80457 | 80458 | 80459 | 80460 | 80461 | 80462 | 80463 | 80464 | 80465 | 80466 | 80467 | 80468 | 80469 | 80470 | 80471 | 80472 | 80473 | 80474 | 80475 | 80476 | 80477 | 80478 | 80479 | 80480 | 80481 | 80482 | 80483 | 80484 | 80485 | 80486 | 80487 | 80488 | 80489 | 80490 | 80491 | 80492 | 80493 | 80494 | 80495 | 80496 | 80497 | 80498 | 80499 | 80500 | 80501 | 80502 | 80503 | 80504 | 80505 | 80506 | 80507 | 80508 | 80509 | 80510 | 80511 | 80512 | 80513 | 80514 | 80515 | 80516 | 80517 | 80518 | 80519 | 80520 | 80521 | 80522 | 80523 | 80524 | 80525 | 80526 | 80527 | 80528 | 80529 | 80530 | 80531 | 80532 | 80533 | 80534 | 80535 | 80536 | 80537 | 80538 | 80539 | 80540 | 80541 | 80542 | 80543 | 80544 | 80545 | 80546 | 80547 | 80548 | 80549 | 80550 | 80551 | 80552 | 80553 | 80554 | 80555 | 80556 | 80557 | 80558 | 80559 | 80560 | 80561 | 80562 | 80563 | 80564 | 80565 | 80566 | 80567 | 80568 | 80569 | 80570 | 80571 | 80572 | 80573 | 80574 | 80575 | 80576 | 80577 | 80578 | 80579 | 80580 | 80581 | 80582 | 80583 | 80584 | 80585 | 80586 | 80587 | 80588 | 80589 | 80590 | 80591 | 80592 | 80593 | 80594 | 80595 | 80596 | 80597 | 80598 | 80599 | 80600 | 80601 | 80602 | 80603 | 80604 | 80605 | 80606 | 80607 | 80608 | 80609 |  |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|-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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, or in any event within 72 hours after death.

VS. A15ME  
5M 2/57MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01938

Reg. Dist. No.

|   |  |   |   |  |  |  |                       |
|---|--|---|---|--|--|--|-----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b>  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>New York</b><br>b. COUNTY                        |  |  |  |                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hopkins Cove, Conowingo</b>  |  |   | c. LENGTH OF STAY IN 1b<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hopkins Cove, Susquehanna River</b> |  |  |  |                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Hopkins Cove, Susquehanna River</b>  |  |   | d. STREET ADDRESS<br><b>69x-3</b>   |  |  |  |                       |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |  |  |  |                       |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>William Henry Meier</b>   |  |   | First   | Middle   | Last   |  |                       |
| 4. DATE<br>OF<br>DEATH<br><b>February 27 1959</b>   |  |   | Month   | Doy  | Year   |  |                       |
| 5. SEX<br><b>Male</b>   |  |   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                         | 8. DATE OF BIRTH<br><b>June 12, 1922</b>             |  |                       |
| 9. AGE (in years<br>last birthday)<br><b>36</b> yrs.  |  |   | 10. IF UNDER 1 YEAR<br>Months <b>1</b>  | 11. IF UNDER 24 HRS.<br>Days <b>0</b>  | 12. IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b> |  |                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Caretaker</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Helicopter</b>  |  |  |  |                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>New York City</b>   |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |                       |
| 13. FATHER'S NAME<br><b>Wm. H. Meier</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Johnston</b>  |  |  |  |                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>123-45-6789</b>   |  |  |  |                       |
| 17. INFORMANT<br><b>Mr. Miles Meier</b>   |  |   | Address<br><b>165 Maynard Street, Bel Air, Md.</b>  |  |  |  |                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Crushing Injury of chest with rupture of heart.</b><br>DUE TO<br><b>863X</b><br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause first.<br>(b)<br>DUE TO<br>(c)<br>DUE TO<br><b>Compound, comminuted fracture of skull</b><br><b>Third Degree Burns.</b>    |  |   |   |  |  |  |                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Helicopter hit power line</b>  |  |   |   |  |  |  |                       |
| 20c. TIME OF INJURY<br>Hour <b>6</b><br>p. m.   |  | Month, Day, Year<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Susquehanna River</b> | 20f. (City or town)<br><b>Conowingo</b>              | (County)<br><b>Harford</b>   | (State)<br><b>Md.</b> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |  |  |  |                       |
| ACTUAL<br>SIGNATURE<br><i>William V. Lovitt</i>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED<br><b>2/28/59</b> |   |  |  |  |                       |
| EXAMINER'S<br>NAME (Type)<br><b>William V. Lovitt Jr., M.D.</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |  |  |  |                       |
| 22a. BURIAL/CREMATION<br>REMOVAL (Specify)<br><b>Burial 28/1959</b>   |  | 22b. DATE THEREOF<br><b>Feb. 28, 1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>New York City</b>                                       |  | 22d. LOCATION (City, town, or county)<br><b>New York City</b> (State)<br><b>NY</b> |                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. S. Bailey</b>   |  | ADDRESS<br><b>10 Arlington St.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 3 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Orville S. Thomas</b>                             |                       |

STATE OF  
MASSACHUSETTS  
GENERAL ASSEMBLY  
1993-1994  
REGULAR SESSION  
BOSTON, MASSACHUSETTS

17

1993-1994 REGULAR SESSION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M 00 I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1943 CERTIFICATE OF DEATH

Reg. Dist. No. 01939

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Harford</i>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><i>Maryland</i> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rocke</i>  |  | b. COUNTY<br><i>Harford</i>  |   |
| c. LENGTH OF STAY IN 1b<br><i>8 yrs</i>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rocke</i>                     |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Home</i>   |  | d. STREET ADDRESS<br><i>—</i>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br><i>JAMES</i>   |  | First<br><i>P.</i>   | Middle<br><i>MILLER</i>   |
| 4. DATE OF DEATH<br><i>FEB 1 1959</i>   |  | Month<br><i>FEB</i>  | Day<br><i>1</i>   |
| 5. SEX<br><i>Male</i>   |  | 6. COLOR OR RACE<br><i>White</i>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><i>May 12, 1913</i>   |  | 9. AGE (In years lost birthday)<br><i>45 yrs.</i>  | 10. IF UNDER 1 YEAR<br>Months<br><i>—</i>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Physician</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>—</i>  | 10c. BIRTHPLACE (State or foreign country)<br><i>Rocke, Md.</i>   |
| 11. FATHER'S NAME<br><i>Henry Condon Lay Miller</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |   |
| 13. MOTHER'S MAIDEN NAME<br><i>Elsie Groof</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>—</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>—</i>   |  | 16. SOCIAL SECURITY NO.<br><i>—</i>  |   |
| 17. INFORMANT<br><i>Mrs. W. D. Pinkard - First National Bank Bldg</i>   |  | Address<br><i>—</i>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |  |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>420.1</i> DUE TO<br>CORONARY Occlusion  |  |  |   |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br>(c)   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |   |
| 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |   |
| 20c. TIME OF INJURY Month, Doy, Year<br>Hour o. m.<br>p. m.<br><i>19</i>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>            |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>(State)   |   |
| 21. I certify that I attended the deceased from <i>Feb 1, 1959</i> to <i>Feb 1, 1959</i> , that I last saw the deceased alive on <i>20 JAN 1959</i> , and that death occurred at <i>1 P. M.</i> from the causes and on the date stated above. |  |  |   |
| ACTUAL<br>SIGNATURE<br><i>Thos. A. E. Moseley, Jr., M.D.</i>  |  | ADDRESS (Street, city or town, state)<br><i>Towson, Md.</i>  |   |
| PHYSICIAN'S<br>NAME (Type)<br><i>Thos. A. E. Moseley, Jr., M.D.</i>   |  | DATE SIGNED  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 22b. DATE THEREOF<br><i>Feb. 3, 1959</i>   |   |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br><i>St. James Cemetery</i>   |  | 22d. LOCATION (City, town, or county)<br><i>My Lady's Manor, Md.</i>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Henry W. Jenkins &amp; Sons Co.</i>  |  | ADDRESS<br><i>4905 YORK, Pa.</i>   |   |
| 24a. REC'D. BY REGISTRAR<br><i>FEB 4 1959</i>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Carla E. Trahan</i>   |   |

CERTIFICATE OF DEATH

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1944

## CERTIFICATE OF DEATH

01940

Reg. Dist. No. ....

|   |                           |  |                                   |  |   |   |   |
|---|---------------------------|--|-----------------------------------|--|---|---|---|
| 1. PLACE OF DEATH   |                           |  |                                   | 2. USUAL RESIDENCE (HOME) OF DECEASED  |   |   |   |
| COUNTY<br>CITY (If outside corporate limits, write RURAL<br>OR and give nearest town)<br>TOWN   |                           | MARYLAND<br>LENGTH OF STAY<br>(in this place)          |                                   | STATE<br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN   |   | COUNTY<br>RURAL<br>STREET<br>ADDRESS                                    |   |
| HARFORD<br>RURAL BEL AIR  |                           | 7 Mos.   |                                   | MD.<br>RURAL   |   | HARFORD<br>PYLESVILLE   |   |
| 3. NAME OF<br>DECEASED<br>(First) (Middle) (Last)   |                           |  |                                   | 4. DATE (Month) (Day) (Year)<br>OF<br>DEATH 2-9- 1959  |   |   |   |
| S. SEX<br>F   | 6. COLOR OR<br>RACE<br>W. | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED,<br>(Specify) | 8. DATE OF BIRTH<br>Oct. 25, 1884 | 9. AGE last birthday<br>74 yrs.  | 10. KIND OF BUSINESS<br>OR INDUSTRY<br>own home | 11. BIRTHPLACE (State or foreign country)<br>YORK Co., PENNA            | 12. CITIZEN OF WHAT<br>COUNTRY?<br>USA. |
| 10a. USUAL OCCUPATION (Give kind of work<br>done during most of working life, even if<br>retired) <b>HOUSEWIFE</b>  |                           |  |                                   | 13. FATHER'S NAME<br>Tom WRIGHT  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unk.)<br>No  |                           |  |                                   | 16. SOCIAL SECURITY NO.  |   |   |   |
| 17. INFORMANT & ADDRESS<br>Laurey Real Pylesville, Md   |                           |  |                                   | 18. MEDICAL CERTIFICATION<br>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br>420.1 IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b><br>ANTECEDENT CAUSE(S) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, (B) <b>Chr. Cardio-vascular disease</b><br>GIVING RISE TO THE ABOVE CAUSE<br>STATING UNDERLYING CAUSE LAST. DUE TO<br>(C) |   |   |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING<br>TO THE DEATH BUT NOT RELATED TO THE<br>DISEASE OR CONDITION CAUSING DEATH.  |                           |  |                                   | 19. DATE OF OPERATION<br>19b. MAJOR FINDINGS OF OPERATION  |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |                           |  |                                   | 21b. PLACE (Home, farm, factory,<br>OF INJURY street, office bldg., etc.)  |   |   |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                           |  |                                   | 21c. WHERE DID INJURY OCCUR? (City or town)<br>(County) (State)  |   |   |   |
| M.  |                           |  |                                   | 21e. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |   |   |   |
| 21f. HOW DID INJURY OCCUR?  |                           |  |                                   |  |   |   |   |
| 22. I hereby certify that I attended the deceased from Sept. 4, 1958, to Feb. 9, 1959, that I last saw the deceased<br>alive on Feb. 8, 1959, and that death occurred at 12 P.M. from the causes and on the date stated above.<br>SIGNATURE <i>Willard P. Hudson</i> M.D. ADDRESS (Street, city, town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>2-9-59</b> |                           |  |                                   |  |   |   |   |
| 23. BURIAL, CREMATION,<br>REMOVAL (SPECIFY)<br><i>Burial</i>  |                           | DATE THEREOF<br>2-12-59                                |                                   | NAME OF CEMETERY OR CREMATORIUM<br><b>SALEM METH. CEM.</b>   |   | LOCATION (City, town, or county)<br><b>DELTA, YORK Co., PA.</b> (State) |   |
| 24. REC'D. BY REGISTRAR<br>DATE FEB 16 '59  |                           | REGISTRAR'S SIGNATURE<br><i>John S. Evans</i>          |                                   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><i>Kenneth W. Hudson, Stewartton, Pa.</i> ADDRESS  |   |   |   |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1924

## CERTIFICATE OF DEATH

01941

Reg. Dist. No.

|  |  |  |   |  |                     |
|--|--|--|---|--|---------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>HARFORD</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>Md.</b>  |   |  |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HARFORD</b>   |  | c. LENGTH OF STAY IN 1b<br><b>45 hrs</b>   |   |  |                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>HARFORD Memorial Hospital</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>STREET</b>  |   |  |                     |
| d. STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |                     |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br><b>Annie</b>  | Middle<br><b>Elizabeth</b>   | Last<br><b>Newcomb</b>  |  |                     |
| 4. DATE OF DEATH   | Month<br><b>FEBRUARY</b>   | Day<br><b>21</b>   | Year<br><b>1959</b>   |  |                     |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPT. 2, 1890</b>  |  |                     |
| 9. AGE (In years<br>lost birthday)<br><b>68</b>  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>  | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>   | 12. IF UNDER 24 HRS.<br>Hours<br><b>0</b>   |  |                     |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>HOUSEWIFE</b>   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTO., Md.</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |                     |
| 13. FATHER'S NAME<br><b>EDWARD COOPER</b>  | 14. MOTHER'S MAIDEN NAME<br><b>MARY DENNIS</b>   | Address<br><b>Mrs. WM. PATRICK, DARLINGTON, MD.</b>  |   |  |                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>—</b>  | 17. INFORMANT<br><b>Mrs. WM. PATRICK, DARLINGTON, MD.</b>  | 18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>442x</b> DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br>(c) | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>—</b>  |                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |   |  |                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)                 |  |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While Not while<br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>STREET</b>  | (County)<br><b>HARFORD Co., MD.</b>  | (State)<br><b>—</b> |
| 21. I certify that I attended the deceased from <b>3/20</b> , 19 <b>59</b> to <b>3/28/59</b> at <b>2B195</b> A.M., from the causes and on the date stated above.<br>alive on <b>3/20</b> , 19 <b>59</b> , and that death occurred at <b>7:30</b> A.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>STREET, HARFORD Co., MD.</b> DATE SIGNED<br><b>3/28/59</b> |  |  |   |  |                     |
| ACTUAL<br>SIGNATURE<br><b>John H. Harbin, Delta, Pa.</b>   | PHYSICIAN'S<br>NAME (Type)   |  |   |  |                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL 3-23-59</b>   | 22b. DATE THEREOF<br><b>3-23-59</b>  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>HOLY CROSS</b>  | 22d. LOCATION (City, town, or county)<br><b>STREET, HARFORD Co., MD.</b>  | (State)<br><b>—</b>  |                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. Harbin, Delta, Pa.</b>  | ADDRESS  | 24a. REC'D BY REGISTRAR<br><b>FEB 26 '59</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Trahan</b>   |  |                     |

BY JEFFREY S. HORNBERGER—MANAGING EDITOR OF THE LIBERTARIAN STATE PROGRAM

18  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01942

Reg. Dist. No.

|   |  |  |  |  |                                 |  |                        |  |  |                     |          |         |
|---|--|--|--|--|---------------------------------|--|------------------------|--|--|---------------------|----------|---------|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | Harford  |  | MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)          |                        |  |  |                     |          |         |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | Harde Grace  |  | c. LENGTH OF STAY IN lb  |                                 | a. STATE Md b. COUNTY Harford  |                        |  |  |                     |          |         |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | Harford Memorial Hospital  |  | 4 days   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)               |                        |  |  |                     |          |         |
| e. STREET ADDRESS   |  |  |  |  |                                 | d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        |  |  |                     |          |         |
| 3. NAME OF DECEASED (Type or print)   |  | First  | Middle   | Lost   | 4. DATE OF DEATH                | Month  | Day                    | Year   |  |                     |          |         |
| 5. SEX F  |  | 6. COLOR OR RACE W   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH | 12-16-38   | 9. AGE (In years last birthday) | 20 yrs.  | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min.                                       |  |                     |          |         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                              |                                 | 12. CITIZEN OF WHAT COUNTRY?   |                        |  |  |                     |          |         |
| Housewife   |  |  |  | Maryland   |                                 | USA  |                        |  |  |                     |          |         |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME   |  |  |                                 |  |                        |  |  |                     |          |         |
| Francis S. Silver   |  | Sarah Elliott  |  | Address  |                                 |  |                        |  |  |                     |          |         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                      |                        |  |  |                     |          |         |
| No  |  |  |  | Sarah E Silver   |                                 | Cerebral contusion   |                        |  |  |                     |          |         |
| PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) DUE TO   |  | 816X   |  | Cerebral contusion   |                                 | INTERVAL BETWEEN ONSET AND DEATH   |                        |  |  |                     |          |         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b)  |  | Q.L. pneumothorax  |                                 | -  |                        |  |  |                     |          |         |
| DUE TO  |  | (c)  |  |  |                                 |  |                        |  |  |                     |          |         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |  |  |  |  |                                 | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        |  |  |                     |          |         |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY Month, Day, Year                                   |                                 | 20d. INJURY OCCURRED   |                        | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or Town) | (County) | (State) |
| Hour a. m. 2-5 p. m. 1959   |  | While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                                 | 20f. (City or Town)  |                        | 20g. (County)  |  | (State)             |          |         |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  | 22. ACTUAL SIGNATURE   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>                   |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                        | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>            |  | DATE SIGNED         |          |         |
| EXAMINER'S NAME (Type)  |  | Gerald E Palmer  |  | M.D.   |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                        | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>            |  | 2-10-59             |          |         |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORIAL                                   |                                 | 22d. LOCATION (City, town, or county)  |                        |  |  |                     |          |         |
| 23. FUNERAL DIRECTOR'S SIGNATURE  |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR  |                                 | 24b. REGISTRAR'S SIGNATURE   |                        |  |  |                     |          |         |
| H. S. Bailey  |  | Harford Co., Md.   |  | FEB 16 '59   |                                 | Arthur S. Thomas   |                        |  |  |                     |          |         |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF EXPENSES  
EXAMINERS CERTIFIED - CALIFORNIA

STATE  
CALIFORNIA

| Item | Description     | Amount   |
|------|-----------------|----------|
| 1    | Travel expenses | \$100.00 |
| 2    | Meals           | \$50.00  |
| 3    | Postage         | \$10.00  |
| 4    | Gasoline        | \$20.00  |
| 5    | Accommodation   | \$100.00 |
| 6    | Other           | \$10.00  |
| 7    | Total           | \$370.00 |

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01943

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEL AIR</b>   |  | c. LENGTH OF STAY IN 1b <b>30 YRS</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>RURAL RD#2 Box 52 SHUCKS Rd</b>  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BEL AIR (RURAL)</b>   |  |
| d. STREET ADDRESS <b>RD#2 Box 52 SHUCKS Rd</b>  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <b>LUTHER</b>   |  | First <b>ESTEL</b> Middle <b>QUILLENN</b>   |  |
| 4. DATE OF DEATH <b>FEbruary 21</b>   |  | Month <b>Day</b> Year <b>1959</b>   |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Nov. 20, 1881</b>   |  | 9. AGE (In years from birthday) <b>77 yrs.</b>  |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>  |  |
| 11. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>   |  | 12. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>   |  |
| 13. FATHER'S NAME <b>MARION QUILLENN</b>  |  | 14. MOTHER'S MAIDEN NAME <b>ELISABETH WALTON</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO. <b>220-24-1301</b> 17. INFORMANT <b>(WIFE) EUWA</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  | Address <b>Schucks Road SAME</b>  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422.1</b>  |  | INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b>  |  |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) ARTERIO SCLEROTIC CARDIO VASULAR DISEASE OVER 3 YRS</b>   |  | ?   |  |
| DUE TO<br>(c)   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour<br>a. m. <b>19</b><br>p. m.   |  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) <b>(County)</b> <b>(State)</b>  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <b>Philip W. Heuman</b>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  |
| EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN</b>  |  | DATE SIGNED <b>February 21, 1959</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>Feb 24/59</b>  |  |
| 22c. NAME OF CEMETERY OR CEMINATORY <b>MF 31</b>  |  | 22d. LOCATION (City, town, or county) <b>Fountain Green Hertford - Md</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph T. Foster</b>  |  | 24a. REC'D BY REGISTRAR <b>DATE FEB 26 '59</b>  |  |
| ADDRESS <b>Bel Air Md</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Carling S. Krasa</b>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY 2000 YEARS - IT HAS TO BE THE SAME PLACE.  
IT HAS TO BE A DIFFERENT 2000 YEARS LATER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1946

### CERTIFICATE OF DEATH

Reg. Dist. No. 01944

|   |  |  |                                     |
|---|--|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>HARFORD</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>   |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ABERDEEN</b>   |  | c. LENGTH OF STAY IN 1b<br><b>31 DAYS</b>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>US ARMY HOSPITAL, APG, MD.</b>   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ABERDEEN</b>  |                                     |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>CLEM</b>   |  | First<br><b>(none)</b>   | Middle<br><b>REID</b>               |
| 4. DATE OF DEATH<br><b>FEBRUARY 28 1959</b>   |  | 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>Colored</b>  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>Sept 23, 1869</b>   |                                     |
| 9. AGE (In years<br>(last birthday)<br><b>89 yrs.</b>   |  | 10. IF UNDER 1 YEAR<br><b>Months</b>   | 11. IF UNDER 24 HRS.<br><b>Days</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farmer</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                     |
| 13. FATHER'S NAME<br><b>George Reid</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |                                     |
| 17. INFORMANT<br><b>James E. Pittman, 103G Rodman Road, Aberdeen, Md</b>  |  | Address  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>CEREBROVASCULAR ACCIDENT</b>   |  | INTERVAL BETWEEN ONSET AND DEATH   |                                     |
| 331X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>GENERALIZED ARTERIOSCLEROSIS   |  | 7 Days   |                                     |
| DUE TO<br>(c)   |  |  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m.<br>19   |  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <b>February 21, 1959</b> , to <b>February 28, 1959</b> , that I last saw the deceased alive on <b>February 27, 1959</b> , and that death occurred at <b>3:05 A.M.</b> from the causes and on the date stated above.<br>ACTUAL SIGNATURE <b>Thomas J. Fraher</b> M.D. US Army Hospital |  | ADDRESS (Street, city or town, state)<br><b>February 28, 59</b>  |                                     |
| PHYSICIAN'S NAME (Type)<br><b>THOMAS J. FRAHER, Captain, MC</b>   |  | DATE SIGNED  |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 22b. DATE THEREOF<br><b>3/2/59</b>   |                                     |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Mt. Hope Baptist</b>   |  | 22d. LOCATION (City, town, or county)<br><b>Jacksonville, Ala. Tanna</b>   |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Elmer E. Bullock</b>   |  | ADDRESS<br><b>Hause de Grace, Md</b>   |                                     |
| 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 4 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Turner</b>  |                                     |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1947

## CERTIFICATE OF DEATH

Reg. Dist. No. 01945

|   |                                  |  |  |   |   |  |                        |                       |
|---|----------------------------------|--|--|---|---|--|------------------------|-----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b>  |                                  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Md.</b> |   | b. COUNTY<br><b>Harford</b>  |                        |                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Whiteford</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>73 years</b>                                 |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Whiteford</b>            |   | d. STREET ADDRESS  |                        |                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION   |                                  |  |  |   |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        |                       |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |                                  | First<br><b>ANNA</b>   | Middle<br><b>WHITEFORD</b>                         | Last<br><b>SILVER</b>   | 4. DATE<br>OF<br>DEATH  | Month<br><b>February</b>   | Day<br><b>17</b>       | Year<br><b>1959</b>   |
| S. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>Dec. 20, 1874</b>           | 9. AGE (In years<br>last birthday)<br><b>84</b><br>yrs.   | IF UNDER 1 YEAR<br>Months<br><b>0</b>                                     | IF UNDER 24 HRS.<br>Days<br><b>0</b>   | Hours<br><b>0</b>      | Min.<br><b>0</b>      |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Insurance Agent</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>                      |  | 11. BIRTHPLACE (State or foreign country)<br><b>Flintville, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                        |                       |
| 13. FATHER'S NAME<br><b>James A. Whiteford</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary L. Gladden</b> |   |   |  |                        |                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |   | Address<br><b>David Silver, Whiteford, Md.</b>   |                        |                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (b), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>443x</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br><b>Cerebral Hemorrhage</b><br><b>12/26/58</b><br><b>Hypertension C-V Disease</b><br>(c)                    |                                  |  |  |   |   |  |                        |                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |  |   |   |  |                        |                       |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.   |                                  | Month<br><b>19</b>   | Day  | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.) | 20f. (City or town)<br><b>Delta</b>  | (County)<br><b>Pa.</b> | (State)<br><b>Pa.</b> |
| 21. I certify that I attended the deceased from <b>1940</b> , to <b>Feb 17</b> , 1959, that I last saw the deceased<br>alive on <b>Feb 16</b> , 1959, and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br><b>Josiah A. Hunt M.D.</b><br>ADDRESS (Street, city or town, state)<br><b>Delta, Pa.</b><br>DATE SIGNED<br><b>2/19/59</b> |                                  |  |  |   |   |  |                        |                       |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Feb. 20, 1959</b>                                  |  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Slateville</b>   |   | 22d. LOCATION (City, town, or county)<br>(State)<br><b>Delta, York Co., Pa.</b>                      |                        |                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. Hartman</b>  |                                  | ADDRESS<br><b>Delta, Pa.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 20 '59</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krause</b>  |                        |                       |

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1926

## CERTIFICATE OF DEATH

Reg. Dist. No.

01946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |   |   |  |   |                              |                               |                   |                          |
|---|--|--|---|---|--|---|------------------------------|-------------------------------|-------------------|--------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE  |   |   |  |   |                              |                               |                   |                          |
| Harford<br>MARYLAND   |  | Md   |   |   |  |   |                              |                               |                   |                          |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | c. LENGTH OF STAY IN 1b<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   |   |  |   |                              |                               |                   |                          |
| Havre-de-Grace  |  | 3 days   |   |   |  |   |                              |                               |                   |                          |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION   |  | d. STREET ADDRESS  |   |   |  |   |                              |                               |                   |                          |
| Harford Memorial Hospital   |  | 1417 Lewis St.   |   |   |  |   |                              |                               |                   |                          |
| e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |   |  |   |                              |                               |                   |                          |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | First<br>Baby  | Middle<br>Boy   |   |  |   |                              |                               |                   |                          |
| 4. DATE<br>OF<br>DEATH  |  | Month<br>2   | Day<br>26   |   |  |   |                              |                               |                   |                          |
| 5. SEX  |  | 6. COLOR OR RACE   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH  | 9. AGE (in years<br>lost birthday)<br>— yrs. | 10. IF UNDER 1 YEAR<br>Months                           | 11. IF UNDER 24 HRS.<br>Days | 12. IF UNDER 24 HRS.<br>Hours | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| Male  |  | White  |   | 2/23/59   |  | —   | 3                            |                               | Jay S. Simons     | Nancy Easter             |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                 |  | 12. CITIZEN OF WHAT COUNTRY?                            |                              |                               |                   |                          |
| None  |  | —  |   | Md.   |  | U.S.A.  |                              |                               |                   |                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |  | Address   |                              |                               |                   |                          |
| —   |  | —  |   | Jay S. Simons   |  | 417 Lewis St. City.                                     |                              |                               |                   |                          |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  | INTERVAL BETWEEN<br>ONSET AND DEATH  |   |   |  |   |                              |                               |                   |                          |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  | Deceased (left 2 lbs)<br>(5-6 month gestation)   |   |   |  |   |                              |                               |                   |                          |
| 776X<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost. (b)   |  |  |   |   |  |   |                              |                               |                   |                          |
| DUE TO<br>C   |  |  |   |   |  |   |                              |                               |                   |                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |   |                              |                               |                   |                          |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |   |                              |                               |                   |                          |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m.   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.) |  | 20f. (City or town)                                     |                              | (County)                      | (State)           |                          |
| 19  |  |  |   |   |  |   |                              |                               |                   |                          |
| 21. I certify that I attended the deceased from 2/23, 1959, to 3/26, 1959, that I last saw the deceased<br>alive on 3/26, 1959, and that death occurred at 10 AM, from the causes and on the date stated above. |  | ADDRESS (Street, city or town, state)  |   |   |  |   |                              |                               |                   |                          |
| ACTUAL<br>SIGNATURE   |  | M.D. <i>Frank Wolbert MD</i>   |   |   |  |   |                              |                               |                   |                          |
| PHYSICIAN'S<br>NAME (Type)  |  | Havre de Grace 2/26/59   |   |   |  |   |                              |                               |                   |                          |
| 22a. BURIAL, CREMATION, OR<br>REMOVAL (Specify)<br>BURIAL   |  | 22b. DATE THEREOF<br>2-28-1959   |   | 22c. NAME OF CEMETERY OR CREMATORIAL<br>FARM G. ALNIS HOUSE               |  | 22d. LOCATION (City, town, or county)<br>HARFORD Co. MD |                              | (State)                       |                   |                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>R. Madison Mitchell, HAVRE DE GRACE, MD</i>  |  | ADDRESS  |   | 24a. REC'D BY REGISTRAR<br>DATE MAR 2 '59                                 |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>    |                              |                               |                   |                          |

## CERTIFICATE OF DATA

Date of issue

Name of company

Address of company

Name of person in charge

Address of person in charge

Name of person in charge

Address of person in charge

Name of person in charge

Address of person in charge

Name of person in charge

Address of person in charge

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Name of person in charge

Address of person in charge

1  
FOR STATE  
HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PHM. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.  
00

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01947

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |  |
| Harford<br>MARYLAND   |  | a. STATE MD<br>b. COUNTY Harford   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | c. LENGTH OF STAY IN 1b<br>24 hours to Grace   |  |
| Harde Grace life  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | d. STREET ADDRESS<br>1700 S. Washington St   |  |
| 700 S Washington St   |  | e. IS RESIDENCE<br>ON A FARM<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | 4. DATE<br>OF<br>DEATH<br>First Middle Last Month Day Year   |  |
| A. Henry Dugan Skipper  |  | February 3 1959  |  |
| 5. SEX F  |  | 6. COLOR OR RACE W   |  |
| 7. MARRIED <input type="checkbox"/>   |  | NEVER MARRIED <input type="checkbox"/>   |  |
| WIDOWED <input type="checkbox"/>  |  | DIVORCED <input checked="" type="checkbox"/>   |  |
| 8. DATE OF BIRTH Dec. 31, 1888  |  | 9. AGE (in years<br>less birthday)<br>70 yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House Wife   |  | 10b. KIND OF BUSINESS OR INDUSTRY Home   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Md.  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME Alexander Dugan   |  | 14. MOTHER'S MAIDEN NAME Sarah Cross   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.  |  |
| (If yes, give war or dates of service)  |  | 17. INFORMANT<br>Albert Dugan Skipper, HARVE DE GRACE, MO  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | Address  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic CVDisease  |  | INTERVAL BETWEEN<br>ONSET AND DEATH  |  |
| 422.1<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause last.<br>(b)   |  |  |  |
| DUE TO<br>(c)   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour<br>o. m.<br>p. m.   |  | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> of work <input type="checkbox"/><br>Not while<br>of work <input type="checkbox"/>                        |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| ACTUAL<br>SIGNATURE<br>Gerald C Palmer  |  | DATE SIGNED<br>Red Air, MD<br>2-3-59   |  |
| EXAMINER'S<br>NAME (Type)<br>Gerald C Palmer MD   |  |  |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  | 22b. DATE THEREOF<br>Feb. 5, 1959  |  |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br>ANGEL HILL Cem  |  | 22d. LOCATION (City, town, or county)<br>HARVE DE GRACE MD   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>R. Madam Mitchell   |  | ADDRESS<br>Harde Grace MO.   |  |
| 24a. REC'D BY REGISTRAR<br>H. 5 '59   |  | 24b. REGISTRAR'S SIGNATURE<br>Cathleen S. Kline  |  |
| VS. A15ME<br>5M 2/57  |  |  |  |



FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1927

01948

Reg. Dist. No.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  |   |
| Harford   |  | a. STATE <input checked="" type="checkbox"/> b. COUNTY Harford   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   |
| Aberdeen  |  | 31 Aberdeen  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | d. STREET ADDRESS  |   |
| Rivers Trailer Camp   |  | 131 W. Phila Blvd.   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First  | Middle  |
| Donald  |  | Middle   |   |
| Engene S Tyler  |  | Last   |   |
| 4. DATE OF DEATH  |  | Month  | Day   |
| February  |  | Year   | 1959  |
| 5. SEX  |  | 6. COLOR OR RACE   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH    |
| M   |  | W  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Dec 8, 1958                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| Lufant  |  | Lufant   |   |
| 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| Maryland  |  | USA  |   |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME   |   |
| Charles L. Tyler  |  | Florence Adams   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.  |   |
| (If yes, give war or dates of service)  |  | 17. INFORMANT  |   |
| No  |  | Father 8 131 W. Phila Blvd Aberdeen  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  | —  |   |
| 491 X<br>DUE TO   |  | Bronchopneumonia   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b)  |   |
| (c)   |  | DUE TO   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour a. m.<br>p. m.  |  | Month, Day, Year<br>19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22. ACTUAL SIGNATURE   |   |
| Gerald E Palmer   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, MD DATE SIGNED<br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2-10-59 |   |
| EXAMINER'S NAME (Type)  |  | 23. BURIAL, CREMATION, REMOVAL (Specify)   |   |
| Burial  |  | 22b. DATE THEREOF<br>2/10/59   |   |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS  |  | 22d. LOCATION (City, town, or county)<br>Aberdeen Maryland (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE  |  | 24a. REC'D BY REGISTRAR<br>FEB 11 '59  |   |
| John G. Berry   |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus  |   |

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M  
5M 2/57

100-24745-12  
12 DECEMBER 1967  
U.S. GOVERNMENT PRINTING OFFICE: 1967

100-24745-12

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1949 CERTIFICATE OF DEATH

01949

Reg. Dist. No. ....

|   |                              |  |                                   |  |                           |   |                               |
|---|------------------------------|--|-----------------------------------|--|---------------------------|---|-------------------------------|
| <b>1. PLACE OF DEATH</b>  |                              |  |                                   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                           |   |                               |
| COUNTY<br>CITY (If outside corporate limits, write RURAL<br>OR end give nearest town)   |                              | Harford MARYLAND   |                                   | STATE Maryland   |                           | COUNTY Harford<br>CITY (If outside corporate limits, write RURAL and give nearest town) |                               |
| TOWN Bel Air Rural  |                              | LENGTH OF STAY<br>(in this place)<br>3 Mons.   |                                   | X STREET<br>ADDRESS  |                           | Jarrettsville<br>(If rural give location)   |                               |
| HOSPITAL OR<br>INSTITUTION OR<br>STREET ADDRESS<br>Harford Convalescing Home  |                              |  |                                   |  |                           |   |                               |
| <b>3. NAME OF<br/>DECEASED<br/>(First) (Middle) (Last)</b><br>BESSIE MAY TRACEY   |                              |  |                                   | <b>4. DATE (Month) (Day) (Year)</b><br>DEATH February 1, 1959                            |                           |   |                               |
| 5. SEX<br>Female  | 6. COLOR OR<br>RACE<br>White | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED,<br>(Specify)<br>Widowed  | 8. DATE OF BIRTH<br>July 16, 1887 | 9. AGE last birthday<br>71 yrs.  | IF UNDER 1 YEAR<br>Months |   | IF UNDER 24 HRS<br>Hours Min. |
| 10e. USUAL OCCUPATION (Give kind of work<br>done during most of working life, even if<br>retired)<br>Practical Nurse Nursing  |                              |  |                                   | 11. BIRTHPLACE (State or foreign country)<br>Rocks Md.                                   |                           |   |                               |
| 13. FATHER'S NAME<br>Thomas Ervin   |                              |  |                                   | 12. CITIZEN OF WHAT<br>COUNTRY?<br>U.S.A.  |                           |   |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unk.)<br>No  |                              |  |                                   | 16. SOCIAL SECURITY NO.<br>215-34-56384  |                           |   |                               |
| 17. INFORMANT & ADDRESS<br>Mrs Helen Crouse Aberdeen Md.  |                              |  |                                   | RD 1   |                           |   |                               |
| <b>18. MEDICAL CERTIFICATION</b>  |                              |  |                                   |  |                           |   |                               |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br>4221 IMMEDIATE CAUSE (A) Bronchopneumonia, terminal<br>ANTECEDENT CAUSE(S) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, (B) Cerebral thromosis, acutely severe<br>GIVING RISE TO THE ABOVE<br>STATING UNDERLYING CAUSE LAST. DUE TO<br>(C) arteriosclerotic cardiovascular disease                             |                              |  |                                   |  |                           |   |                               |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING<br>TO THE DEATH BUT NOT RELATED TO THE<br>DISEASE OR CONDITION CAUSING DEATH. carcinoma of cervix (treated 4 months ago; arrested) 1 year  |                              |  |                                   |  |                           |   |                               |
| 19e. DATE OF OPERATION  |                              | 19b. MAJOR FINDINGS OF OPERATION   |                                   |  |                           |   |                               |
| 21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 21b. PLACE (Home, farm, factory,<br>OF INJURY street, office bldg., etc.)                                    |                                   | 21c. WHERE DID INJURY OCCUR? (City or town)<br>(County) (State)                          |                           |   |                               |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                              | 21e. INJURY OCCURRED<br>M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                   | 21f. HOW DID INJURY OCCUR?   |                           |   |                               |
| 22. I hereby certify that I attended the deceased from Sept. 5, 1959, to Feb. 1, 1959, that I last saw the deceased<br>alive on Feb. 1, 1959, and that death occurred at 4:30 AM, from the causes and on the date stated above.<br>SIGNATURE <i>Paul S. Stoner Jr.</i> ADDRESS (Street, city, town, state) M.D. 115 Fulford Ave., Bel Air, Md. DATE SIGNED 2/2/59 |                              |  |                                   |  |                           |   |                               |
| 23. BURIAL, CREMATION,<br>REMOVAL (SPECIFY)<br>Burial   |                              | DATE THEREOF<br>2/5/1959   |                                   | NAME OF CEMETERY OR CREMATORIAL<br>North Bend  |                           | LOCATION (City, town, or county)<br>Rocks Rd. (State) Md.                               |                               |
| 24. REC'D BY REGISTRAR<br>FEB 4 '59   |                              | REGISTRAR'S SIGNATURE<br><i>Arthur S. Kline</i>  |                                   | 25. FUNERAL DIRECTOR'S SIGNATURE<br>ADDRESS<br><i>Charles C. Hurtz Jarrettsville</i> Md. |                           |   |                               |



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**Reg. Dist. No.**

01950

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                              |   |   |   |  |
|---|------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Hayford</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Conowingo</b>   |                              |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Hayford</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Darlington</b> |   |  |
| c. LENGTH OF STAY IN 1b<br><b>Hykins Cove, Susquehanna River</b>  |                              |   | d. STREET ADDRESS<br><b>Hykins Cove, Susquehanna River</b>  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Hykins Cove, Susquehanna River</b>   |                              |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>Robert E. Turner</b>  |                              | First<br><b>R</b>   | Middle<br><b>E.</b>   | Last<br><b>Turner</b>   | 4. DATE<br>OF<br>DEATH <b>February 27, 1959</b>  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH<br><b>MAR. 13, 1901</b>  | 9. AGE (In years<br>at time of death)<br><b>58</b><br>yrs.  | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>0</b><br>Hours <b>0</b> Min. <b>0</b><br>11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PLANT ENGINEER</b>  |                              |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HYDRO-ELECTRIC</b>  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>ODEBOLT, Iowa</b>   |                              |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |  |
| 13. FATHER'S NAME<br><b>George Turner</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>MARTHA HENDERSON</b>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |                              |   | 16. SOCIAL SECURITY NO.<br><b>174-10-7D33</b>   |   |  |
| 17. INFORMANT<br><b>REBECCA TURNER, Conowingo, MD.</b>  |                              |   | Address   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Skull</b><br>863X<br>DUE TO<br>Fracture<br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause last.<br>(b)<br>DUE TO<br>Fracture L femur<br>(c)<br>DUE TO<br>Third Degree Burn Body   |                              |   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Helicopter hit power line</b>                                 |                              |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>6</b> am. <b>2-27</b> <b>59</b><br>p. m. <b>19</b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Susquehanna River, Conowingo, Hayford, Md.</b> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |   |   |  |
| ACTUAL<br>SIGNATURE<br><b>Gerald C Palmer</b>   |                              | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |   | DATE SIGNED<br><b>Bel Air, Md</b><br><b>2-27-59</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                              | 22b. DATE THEREOF<br><b>MAR 2, 1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>DARLINGTON</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. Hartman, Delta, Pa.</b>  |                              |   | 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 3 '59</b>   |   |  |
| ADDRESS<br><b>John H. Hartman, Delta, Pa.</b>   |                              |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krause</b>   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1928

### CERTIFICATE OF DEATH

01951

Reg. Dist. No.

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Harford</b>   |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Harford</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>2 Years</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>319 Graceford Drive</b>  |                                  | d. STREET ADDRESS<br><b>319 Graceford Drive</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LEO FRANCIS VANCE</b>   |                                  | First<br><b>LEO</b>   | Middle<br><b>FRANCIS</b>                 | Last<br><b>VANCE</b>  | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>6</b> Year <b>1959</b>   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 22, 1918</b> | 9. AGE (In years<br>last birthday)<br><b>40</b> yrs.  | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Army Officer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>US Army</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>William Francis Vance</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>WWII, Korean 214-07-4060</b>  |  | 17. INFORMANT<br><b>Official Military Records</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe Coronary Arteriosclerosis and fatty</b><br>DUE TO <b>liver.</b><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last. (b)<br>DUE TO<br>(c) |                                  |   |  |   |   |
| INTERVAL BETWEEN<br>ONSET AND DEATH  |                                  |   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  |                                  |   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State)                             |   |
| 21. I certify that I attended the deceased from <b>Feb 6, 1959</b> to <b>Feb 6, 1959</b> that I last saw the deceased<br>alive on <b>Feb 6, 1959</b> , and that death occurred at <b>Approx. 3:15P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>Aberdeen Proving Ground, Md</b>       |                                  |   |  |   |   |
| DATE SIGNED<br><b>Feb 6, 1959</b>  |                                  |   |  |   |   |
| ACTUAL SIGNATURE <i>Jerome B. Bryant Jr., Major, MC</i> M.D. US Army Hospital  |                                  |   |  |   |   |
| PHYSICIAN'S NAME (Type) <b>Jerome B. BRYANT Jr., Major, MC</b>   |                                  |   |  |   |   |
| 22a. BURIAL, CREMATION OR<br>REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>2-10-59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Arlington National Cem.</b>  |   |
| 22d. LOCATION (City, town, or county)<br><b>Arlington, Va.</b>   |                                  |   |  |   |   |
| (State)  |                                  |   |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. Cook - Blight Inc. 6009 Harford Rd. Balti-<br/>Md.</b>  |                                  |   |  |   |   |
| ADDRESS  |                                  |   |  |   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 '59</b>  |                                  |   |  |   |   |
| 24b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Krause</i>  |                                  |   |  |   |   |

EL AGRICULTOR DE LOS ESTADOS UNIDOS

ESTADO DE MICHIGAN

17

1892

1892

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1929

## CERTIFICATE OF DEATH

Reg. Dist. No. 01952

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>HARFORD</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residencia before admission)<br>a. STATE<br><b>MARYLAND</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HARVE DE GRACE</b>   |  | c. LENGTH OF STAY IN 1b<br><b>25 Hrs</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>HARFORD Memorial Hosp.</b>  |  | d. STREET ADDRESS   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>Baby Boy WAHIS</b>  |  | 4. DATE<br>OF<br>DEATH<br><b>FEbruary 12 1959</b>   |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>2-1-59</b>   |  |
| 9. AGE (In years<br>lost birthday)<br>yrs.<br><b>24</b>   |  | 10. IF UNDER 1/4 YEAR IF UNDER 24 HRS.<br>Months<br><b>5</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAREN NAME<br><b>MARION WAHIS</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>(If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>762.5</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |   |  |
| INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>12 Hrs.</b>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                          |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  |  | 20d. INJURY OCCURRED<br>White Not white<br>at work <input type="checkbox"/> at work <input type="checkbox"/>          |  |
| 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)   |  | 20f. (City or town)<br>(County) (State)   |  |
| 21. I certify that I attended the deceased from <b>2/11, 1959</b> , to <b>2/12, 1959</b> , that I last saw the deceased<br>alive on <b>2/12, 1959</b> , and that death occurred at <b>626</b> M., from the causes and on the date stated above.   |  |   |  |
| ACTUAL<br>SIGNATURE<br><i>J. P. Ross</i>  |  | M.D. <b>200 Agt Grace Ave.</b>  |  |
| PHYSICIAN'S<br>NAME (Type)<br><b>J. P. Ross</b>   |  | ADDRESS<br><b>Hause de Grace, Md.</b>   |  |
| 22a. BURIAL, CREMATION,<br>REMASS (Specify)<br><b>2-2-59</b>  |  | 22b. DATE THEREOF<br><b>2-2-59</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>HARFORD MEMORIAL HOSPITAL</b>  |  | 22d. LOCATION (City, town, or county)<br><b>Hause de Grace Md</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Henry A. Tracy, administrator</b>  |  | ADDRESS<br><b>2071203 XVI</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 6 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Orlina S. Trahan</b>   |  |

35 ДРОМІСТІС-ІНДІЯ ЗО ТАКИДАЧІО ЗІАУС ОНАЛІУАД

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1930

## CERTIFICATE OF DEATH

Reg. Dist. No.

01953

|  |  |  |  |   |   |  |     |   |  |   |  |
|--|--|--|--|---|---|--|-----|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Harford</i>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Hause de Grace</i>  |  | c. LENGTH OF STAY IN 1b<br>RURAL and give nearest town)   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><i>Ohio</i> |     | b. COUNTY<br><i>Cuyahoga</i>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Cleveland - 6 72x-3</i>    |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Harford Memorial Hospital</i>   |  | d. STREET ADDRESS<br><i>2128 East 100<sup>th</sup> Street</i>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   |  |     |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><i>HATTIE MILDRED WILLIAMS</i>  |  | First  | Middle   | Last  | 4. DATE OF DEATH<br><i>February 20 1959</i> | Month  | Day | Year  |  |   |  |
| 5. SEX<br><i>Female</i>  |  | 6. COLOR OR RACE<br><i>Negro</i>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Sept. 28, 1912</i>   |   | 9. AGE (In years last birthday)<br><i>46 yrs.</i>  |     | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <i>5</i> Days <i>8</i> Hours <i>0</i> Min.                 |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>- -   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Cincinnati, Ohio</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |     |   |  |   |  |
| 13. FATHER'S NAME<br><i>Thomas Childs</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Hattie Kelley</i>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>- - -                                 |   | 16. SOCIAL SECURITY NO.<br><i>355-18-6884</i>  |     | 17. INFORMANT<br><i>Mr. Joseph Williams</i>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>Congestive Heart Failure</i>  |  | DUE TO<br><i>416X</i>  |  | b)<br><i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> |   | c)<br><i>Chronic Rheumatic Heart disease</i>   |     | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                |   | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br>19   |     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |  |
| 21. I certify that I attended the deceased from _____, <i>2/15</i> , 19 <i>59</i> , to _____, <i>2/20</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2/20</i> , 19 <i>59</i> , and that death occurred at <i>4:10A.M.</i> from the causes and on the date stated above. |  | ACTUAL SIGNATURE<br><i>George T. Stansbury</i>   |  | PHYSICIAN'S NAME (Type)<br><i>George T. Stansbury</i>   |   | ADDRESS (Street, city or town, state)<br><i>22 Revolution St. Havre de Grace, Md.</i>                            |     | DATE SIGNED<br><i>2/20/59</i>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>  |  | 22b. DATE THEREOF<br><i>2/21/59</i>  |  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><i>Highland Park Cemetery</i>                                       |   | 22d. LOCATION (City, town, or county)<br><i>Cleveland Ohio</i>   |     | (State)   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Elmer E. Bullock - Hause de Grace</i>   |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br>DATE <i>FEB 24 '59</i>   |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Krause</i>  |     |   |  |   |  |

THE STATE DEPARTMENT OF HEALTH - BIRMINGHAM  
CERTIFICATE OF DEATH

1935

1  
1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

01954

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |  |
| Harford  |  | a. STATE <input checked="" type="checkbox"/> Md                                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |  | b. COUNTY <input checked="" type="checkbox"/> Harford                                 |  |
| Bel Air  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)     |  | x Churchville   |  |
| RDI  |  | e. STREET ADDRESS   |  |

|  |                  |  |                                     |
|--|------------------|--|-------------------------------------|
| 3. NAME OF DECEASED<br>(Type or print) | First            | Middle   | 4. DATE OF DEATH                    |
| Joan                                   | Dell             | Wilson   | February 28 1959                    |
| 5. SEX                                 | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH | 9. AGE (In years<br>legal birthday) |
| F                                      | W                | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 14 Sept. 1942                       | 16 yrs.                             |

|   |                                   |   |                              |
|---|-----------------------------------|---|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Student   | School                            | Maryland                                  | U.S.A.                       |

|                       |                          |
|-----------------------|--------------------------|
| 13. FATHER'S NAME     | 14. MOTHER'S MAIDEN NAME |
| Thomas Woodrow Wilson | Ruby Mae Lynch           |

|   |                         |               |                       |
|---|-------------------------|---------------|-----------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address               |
| No  | —                       | T.W. Wilson,  | Churchville, Maryland |

|   |  |                                     |
|---|--|-------------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]                                       |  | INTERVAL BETWEEN<br>ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |                                     |
| 816X<br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause last. |  | Fracture Spull                      |
| DUE TO<br>(b)   |  | Fracture L femur                    |
| DUE TO<br>(c)   |  |                                     |

|  |  |   |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  | 19. WAS AUTOPSY<br>PERFORMED?                                       |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

|  |  |  |  |  |                                      |
|--|--|--|--|--|--------------------------------------|
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) |  | 20c. TIME OF INJURY                    | 20d. INJURY OCCURRED   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| An accident auto - auto type   |  | Month, Day, Year<br>Hour<br>11 58 p.m. | While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | R 7 2  | Bel Air Harford Md                   |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |
|---|--|--|--|--|--|

|                           |                    |  |  |
|---------------------------|--------------------|--|--|
| ACTUAL<br>SIGNATURE       | Gerald C Palmer    |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md DATE SIGNED |
| EXAMINER'S<br>NAME (Type) | Gerald C Palmer MD |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                          |
| EXAMINER'S<br>NAME (Type) | Gerald C Palmer MD |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |

|   |                   |  |   |
|---|-------------------|--|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS | 22d. LOCATION (City, town, or county) (State) |
| Removal                                   | 3/3/59            | Miller Cemetery                              | Webster Springs, W. Va.                       |

|                                  |                         |                            |
|----------------------------------|-------------------------|----------------------------|
| 23. FUNERAL DIRECTOR'S SIGNATURE | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE |
| John G. Barrueg                  | DATE MAR 4 '59          | Arthur S. Kline            |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

